Medical Oaths and the Social Contract – Do We Say the Same Words?

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From the Editor - Janet de Groot

Dear Readers,

At Professional Formation we are fortunate to have an increasingly international perspective This month, we are publishing articles by authors from Brazil, the United States and Canada. Preston Reynolds', Professor of Medicine and Nursing at the University of Virginia and APHC Board Chair, article provides a valuable historical perspective on the role of social justice, a key principle of *Medical Professionalism in the New Millennium: A Physician Charter*, a document accepted by over 100 organizations. This historical background contributes importantly to how we understand, educate for and integrate social justice into professionalism and is foundational to our preparation for our annual conference.

We have a scholarly, personal reflection about medical oaths and the social contract from Marco Antonio de Carvalho Filho's deep engagement with medical practice and education. His narrative includes the statement, "*practicing good and ethical medicine is also an act of resistance,"* which encourages reflection on professional identity formation. As an Associate Professor of Emergency Medicine and medical educator, he encourages an inclusive re-evaluation of our social contract and medical oath.

The article by Tom Koch provides an alternative perspective on the challenges of professional identity formation in relation to organizational culture. Further, Leann Poston's book review of "Ethics in Everyday Places: Mapping Moral Stress, Distress and Injury" provides a broader perspective of Tom Koch's (2018) writing and ethical analyses of how big data is interpreted and utilized. Certainly, it challenges ethical perspectives.

In conjunction with this month's articles and book review, I believe it may be useful to refer back to Lesser et al's (1) article written for a broad medical audience, on individual and organizational professional behaviours that provides a systems view of professionalism. There is recognition of the necessity of ongoing development and self awareness to sustain and contribute to individual and organizational professionalism as a health professional and learner.

Best regards,
Janet

Janet de Groot, MD, FRCPC, M.Med.Sc.- Founding Editor, APHC-PFO Newsletter

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APHC Call for Proposals
7th Annual Meeting
May 15 to 17, 2019
New Orleans

Social Justice and Professionalism: Exploring the Challenges and Opportunities

The 2019 APHC annual meeting will explore social justice in health professions education and practice. Social justice is emphasized as a key value in The Charter on Medical Professionalism, Code of Ethics for Social Work, and the Code of Ethics for Nursing.

We will address:
• What does our experience with healthcare in the 21st century tell us about successes, failures, and opportunities in embracing social justice as a professional value?
• What is our path moving forward?

Please submit abstracts related to social justice in practice, education and experience and join us for a robust discussion. While submissions related to social justice education and practice are encouraged, we continue to welcome abstracts focused on general professionalism and professional formation as well, all making for a rich and invigorating program. **www.academy-professionalism.org**
Abstracts (4000 characters max) will be blind reviewed.

We welcome submissions for:
• Oral Presentations (30 min) – Oral presentations should present data and raise new or novel questions
• Panel Discussions (60 min) – Panel discussions should be interdisciplinary and explore various facets of a single topic.
• Workshops (60 or 90 min) – Workshops should be interactive and teach processes or methods that can be adopted by participants.
• Posters (scheduled poster sessions) – Posters should describe research, innovative educational or practice initiatives, or offer visual depictions of conceptual work.
• Flash Presentations (5 min) – Brief reports of research

For more information: info@academy-professionalism.org

Abstracts due Thursday, November 15 -- Less than 3 weeks

Professionalism, Social Justice and the Global Right to Health

by P. Preston Reynolds

The Physician Charter, recognized by health professionals around the world as one of the defining documents on medical professionalism in the new millennium, lays out three key principles, one being social justice.

Principle of social justice: The medical profession must promote justice in health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion or any other social category.

This essay considers the right to health as a foundation to the principle of social justice, a right that health professionals accept throughout the world, but a right that is still contested in the United States.

The concept of universal rights emerged as a cornerstone of the Charter of the United Nation (UN), adopted by 51 nations in 1945, in the aftermath of World War II. Shortly thereafter, the UN General Assembly established a Commission on Human Rights (CHR) and charged it with creating a statement on global human rights.

Under the leadership of Eleanor Roosevelt, the 18-member Commission on Human Rights sought input from individuals and organizations from every corner of the world in an effort to capture ideas that reflected various religious traditions, political philosophies and human experiences. The Commission members themselves embodied breath-taking expertise and a depth of knowledge in their lives as scholars, lawyers, diplomats, theologians, writers and citizens of the world. Over the next three years, CHR members and UN delegates together drafted and refined their statement on global human rights. In December 1948, with unanimous support, representatives of 48 countries adopted the Universal Declaration of Human Rights. Article 25 states:

Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The Universal Declaration on Human Rights, along with the Covenant on Civil and Political Rights and the Covenant on Economic, Social and Culture Rights comprise the global Bill of Human Rights. Together, they led to the creation of additional international human rights treaties that further elaborate on this and other basic human rights.

The right to health, a cornerstone of universal human rights was captured also when the UN established the World Health Organization (WHO). Delegates to the first International Health Conference held in 1946, adopted the Charter of the WHO that from its inception defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This Charter further states, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

Over the past 40 years, the right to health has been upheld and expanded globally. International treaties now incorporate measures of accountability to ensure that nations who have signed onto these treaties are fulfilling their obligations to create living conditions and healthcare systems that enable their citizens to lead productive and healthy lives.

The core international human rights documents that support the right to health include:

- International Covenant on Economic, Social and Cultural Rights and the Committee on Economic, Social and Cultural Rights’ General Comment #14 and General Comment #16
- International Convention on the Rights of Children
- Convention on the Elimination of All Forms of Discrimination against Women
- Convention on the Elimination of All Forms of Racial Discrimination
- Convention on the Rights of Indigenous People
- International Treaty to Ban Landmines
- Convention on the Rights of Disabled Persons
- Refugee Convention

Furthermore, the right to health has been incorporated into national constitutions. The impact of this constitutional language has been far reaching. For South Africa, its constitutional right to health provisions enabled health professionals, working with human rights experts in a global campaign, secure access to anti-retroviral medications that

helped stem the AIDS epidemic and build out the infrastructure for delivery of education and treatment.

Achieving equity in health, a priority of the WHO, necessitates a social justice framework of action, one that rests on the right to health as a fundamental right simply because we are alive here and now. Social justice mandates that we direct resources to mitigate past discriminations to level the playing field, thus allowing everyone to reach their full potential. Achieving equity in health requires us to eliminate health disparities within our own country and between countries.

This seems like a daunting task, but one only needs to look at the work of WHO with its Millennium Development Goals to see the realization of the right to health in marginalized populations and developing nations around the world.

P. Preston Reynolds, MD, PhD, MACP, is Chair of the APHC Board of Directors and Professor of Medicine and Nursing at the University of Virginia.

Medical Oaths and the Social Contract – Do We Say the Same Words?

by Marco Antonio de Carvalho Filho

Recently, Greiner and Kaldjian authored an article in Medical Education discussing the different contents of medical oaths in North American medical schools (1). The authors observed a variety of different concepts, ideas and, most importantly, values used by the various medical schools. In some of them, students had the freedom to decide about the nature of the statement they would profess at the end of the course. The authors concluded that there is a lower degree of concordance among the oaths regarding their guiding ethical principles. If we agree that medical oaths are symbols of our social contracts, what does this plurality mean to us and to medical students? Do we have different commitments to society? Is it up to local schools to choose or change the nature of our social contracts?

My first contact, as a medical student, with the Hippocratic oath stroked me with a question: Why did Hippocrates need to state the obvious? Is it not clear that we need to protect patients' privacy or not use patients' information to profit for ourselves? I was a naïve and optimistic young man at that time. With the years, the experience and after some disappointments – in a sort of reality check - I realized that practicing good and ethical medicine is also an act of resistance. Practicing under the guidance of the ethical principles is to fight constantly against the selfish nature of our genome. Pride, greed, envy and other deadly sins surround our daily activities. Virtue comes from a struggle, and medical oaths are a public way of showing how committed we are. If I profess my professional values loudly, the society in general and the patients, in particular, can follow my words and ask for coherence while witnessing my attitudes and behaviors. Social supervision is a necessary nest to breed social accountability.

Words matter. My grandfather, a wise illiterate farmer, my ethical mentor, used to say that if you cannot trust a man's (or woman's – please, forgive grandpa) words, this person has no value. Because I learned to pay attention to words, I was impressed by the variety of medical oaths in North America. Although it is true that some elements of the Hippocratic oath are outdated, particularly the lack of mention to equity and social accountability, we need to be conscious and careful during the process of modernizing our consecrated oath (2). Deliberating about the oath is also deciding about the nature of our social contract or at least about how society will perceive it. The idea of every school supporting a different oath can send the message that our social contract depends on the locale where we were trained.

Rituals also matter. Although I am a strong advocate for students' engagement, the idea of inviting students to change our oath can send the wrong message about the meaning of professional autonomy. Medical doctors are free to behave in accordance with our ethical code. Surely, our social contract is not immutable; it is a product of a permanent negotiation that suffers the influence of different social agents. Students are one of those

agents. Students bring fresh ideas, motivation, diversity; students renew outdated social practices and open our eyes to understating societal changes. However, students do not have the big picture of a doctor's work. This lack of an overview, this lack of awareness and experience, prevents them from speaking for all the medical community. When students profess the oath, they are asking permission to enter our professional community; a community that is also a moral community committed to specific values; values that we want to preserve.

Maybe it is time to modernize our oath. Discussing a new version for our oath opens the door for debating our social contract (3). This discussion is an opportunity to contextualize our traditional values to address the current needs of patients and society. It is also an opportunity to bring new values to the table, like social justice and equity, both crucial elements in a time of profound economic inequality within and across national borders. Getting to a new social contract is not a local endeavor. Ideally, this discussion should break the academic barrier and involve not only students and medical educators, but also physicians, patients, health professionals, healthcare regulators and managers. I salute medical schools for starting the conversation, but let's open the door and free places at the table. A contract is good when it works both for both sides.

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Professionalism's Moral Injury

by Tom Koch

Those who doubt the chasm that separates "professionalism" as an ideal and the realities of medicine practice[1] might consider this: Physicians are more likely to commit suicide than US military personnel and veterans (28-40 versus 20.6 per 1000,000).[2] Compared to the general population, physicians are nearly twice as likely to commute suicide: 1.87 times higher than the average American, according to findings from one study.[3] At least since 1996, with the introduction of "professionalism" as a key to "identify formation," practitioners have by every measure been seen more at risk than average members of society.[4]

Although early symptoms may be similar, the problem is not simple "burnout" resulting from the grind of practice but the moral injury that accrues in a health system of irremediably conflicted, simultaneously demanding allegiances – to patients, to employers and governing bureaucracies.[5] The resulting injury results stems from the gulf between an ethical perspective based on moral values and the directives of supervising powers.[6] Others have noted the moral distress of students struggling to hold to ethical ideals and moral perspectives in the face of classroom and clinical experiences.[7] That practitioners suffer similarly and over time more severely, should be no surprise.

"Professionalism" must shoulder the responsibility for student and practitioner distress. After all, when first advanced as a core teaching focus it promised to promote the long-term maturation and satisfaction of practitioners acting vocationally in service of patient needs and satisfaction.[8] It ignored from the start, however, the constraints imposed upon that moral mission by economic priorities, institutional policies and political realities.

None of this stems from some "hidden agenda"[9] but reflects one bioethicists promoted for years.[10] First, they insisted because medical knowledge was primarily technical, not ethical or experiential, practitioners were incompetent to deal with issues of ethics or organization. They then declared the cost of medical care more important than the care of the patient. Hastings Center co-founder and director Daniel Callahan led the charge arguing, as Rothman put it, that physicians must serve "the common good and collective health of society, not the particularized good of individuals."[11] That good was economic efficiency in a corporate environment, not medicine's Hippocratic vocational *raison d'être*: the care of persons. [12]

Relief will not result from courses in empathy, humanities or values[13] when those virtues are stymied by a system that places economic efficiency over patient need. It will come, if at all, from an insistence that any "social contract"[14] be negotiated to assure the importance of practitioner experience, perspectives and medicine's traditional Hippocratic mission.

Tom Koch is a Canadian-based ethicist and gerontologist consulting in chronic and palliative care. http://kochworks.com.

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Ethics in Everyday Places: Mapping Moral Stress, Distress and Injury

Book Review by Leann Poston

My first impression when looking at the table of contents for *Ethics in Everyday Places: Mapping Moral Stress, Distress and Injury* was to question how the author could tie something so defined and prescriptive as map making to something as esoteric and illusive as ethics and morality. Tom Koch, PhD Adjunct Professor of Medical Geography at the University of British Columbia, a consultant in ethics and gerontology at Alton Medical Centre Toronto, and Director of Information Outreach, Ltd. does a masterful job of making the connections and demonstrating how even the most mundane of tasks can have significant ethical implications. He draws the reader in and makes the content relevant to all by asking each reader to consider the uncomfortable feeling they get when they are doing what they are told or what they feel is right but still have the feeling that something is just not right.

Dr. Koch makes his points with a series of case studies which are easy to follow and encourage the reader to ponder the implications of the misuse of statistics and misleading mapmaking. In one such case study, Koch asks his students and later participants in a seminar, what they would do if given a contract to develop a map based on data demonstrating the longevity of smokers. He then leads the reader through an analysis of statistics and how the data can lead to the conclusions desired by the researcher, the feeling of unease one gets with the statement that "it's just business" and the assumption that the product of a technician does not have ethical implications. Most students end up deciding to honor the contract; generally, because they cannot afford not to. They ease their conscience with the statement that it is not the maps that hurt people, but the people who interpret the map. A correlate to the sentiment that guns do not kill, people do. Koch summarizes on page 114 with the Supreme Court argument that "intentions do not matter when the results are disastrous. When that happens, our communal moral declarations are violated, and we are all complicit."

Koch's other case studies look at the practice of "redlining" and mapping poverty to determine eligibility for bank loans, the inequity of school district financing, the inaccessibility of the transportation system in London, mapping the path of Hurricane Katrina, longevity in tobacco users and patient access to hospitals capable of organ transplantation. Dr. Koch researches and provides data on the relationship between race and the likelihood of donating and receiving an organ transplantation. His point is not so much about the data, but that we are not asking appropriate questions. Why have we not questioned the lack of correlation between numbers of donors and number of recipients when examined along racial lines? We go about our business, sometimes even lifesaving work, but not take the time to explore the ethics and moral choices we are making while completing these tasks.

So how does this happen? Why do we feel that we live ethically and have strong moral principles, but these case studies give evidence to the contrary? One theory is distance. The closer we are to the inequity the more we are compelled to help. Likewise, the greater the distance, the lesser the feeling. Another is that numbers without context can lose their meaning. The percent of people living in poverty is a number without a face. We lose the connection to the faces of the people suffering and the outcomes of this suffering. Koch states on page 179 that data does not speak through us, we speak through the data. Koch ends by stating that his book is not written to be a call to action, but a call to awareness and a realization that our choices matter and have consequences. The reader is left with the disquieting feeling that his points are all valid and have merit, but the issues seem so enormous. We can recognize the problems but feel helpless to provide a solution.

Koch, T. (2018). *Ethics in Everyday Places: Mapping Moral Stress, Distress, and Injury*. MIT Press.284 pages, ISBN 978-0-262-03721-1

Leann Poston, MD is a pediatrician in Dayton, Ohio.

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